Safe Motherhood Campaign

Monitoring and Evaluation Plan

CSH Project

March 2012

I. Introduction

Background on Maternal Health Situation in Zambia

Zambia as a nation has made extensive progress in recent years towards achieving the Millennium Development Goals. The Zambian health system continues to improve and access to services is increasing. However, a number of health issues persist. One critical issue is maternal mortality. Zambia's maternal mortality ratio of 591/100, 000 live births[1] ranks among the highest in the world. This mortality is attributable to a number of complex and interwoven factors. Low contraceptive use in Zambia has resulted in high fertility trends over the years, with a current average fertility rate per woman of 6.3[2]. Only about half of pregnant women initiate antenatal care by 5.1 months of gestation,[3] preventing the opportunity for early detection of danger signs and adequate management of maternal complications.

Over half (52%) of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5% as compared to 15.7%). But even when a woman delivers in a facility, utilization of postpartum care services is extremely low. Nationwide, more than half (51%) of women do not receive any postnatal care.[4]

To directly address these challenges, the Government of the Republic of Zambia (GRZ), as party to the CARMMA framework, is launching aggressive efforts in both service delivery and creation of demand for services with the goal of reducing its MMR to 162/100,000 by 2015.

In support of this effort, the United States government, through its Communication Support for Health (CSH) project, is supporting the GRZ in launching a national "campaign to promote safe motherhood." CSH and the GRZ, together with a number of implementing stakeholders, have identified several key areas where demand creation and individual and collective behavior change are critical to the success of the initiatives. Specifically, women should choose and practice a modern contraception method prior to their first and between subsequent pregnancies; once pregnant, women and their partners need to understand the importance of and seek early antenatal care, complete at least four ANC visits prior to delivery, plan for and deliver their baby in a facility, and seek adequate post-partum follow-up at prescribed intervals after the baby is born (6 hours, 6 days and 6 weeks). The campaign to promote these behaviors will run from 2012 until at least 2014.

Safe Motherhood Campaign

The Safe Motherhood Campaign is a national behavior change communication campaign focused on changing behaviors related to antenatal care, family planning, delivery and post-partum care, ultimately contributing to the reduction in maternal mortality in Zambia. The campaign will be launched in March 2012 and is expected to run for two years until March 2014. The specific goals and objectives for the campaign are outlined in the M&E Framework for the campaign in Section 3 below.

[1] Zambia Demographic and Health Survey, 2007
[2] World Bank Development Indicators, 2009
[3] Zambia Demographic and Health Survey, 2007
[4] Zambia Demographic and Health Survey, 2007

The primary audience for the campaign and the promotion of the key behaviors is pregnant women. The secondary target audiences for the campaign include the following: relevant family and community members, namely Safe Mother Action Groups (SMAGs), partners of pregnant women, traditional leaders, extended family members of pregnant women, and the community at large. Because the rates of facility based deliveries and complete antenatal care attendance in the rural areas is much lower than the urban areas, the focus of many of the campaign community level activities will be in the rural areas. However, urban women will still be exposed to the mass media components of the campaign.

A formative research study and literature review were conducted and used to inform the goals, communication objectives, and strategies of the campaign. The campaign will include products and activities at the following levels: 1) the community level; 2) health facility; and 3) national level via different mass media forums. Community level activities include counseling and education through SMAGs and community health volunteers, carrying out a "Change Champions" program led by traditional and other community leaders and having community level radio discussions. At the health facility level, activities include videos and radio programs; working with health workers to provide additional counseling; developing counseling checklists and picture-based birth plans for health workers; and development of posters to display in health facilities. For mass media, the activities will include radio spots, TV and radio documentary series, champion chiefs documentary, province-specific radio ads featuring local chiefs, newspaper inserts, fliers, pamphlets, billboards and SMS.

II. Objectives of the M&E Plan

The objectives of the M&E plan for Safe Motherhood are threefold: 1) to provide relevant and timely information to determine if the campaign activities and strategies are being implemented according to plan and reaching the targeted audience(s); 2) to provide information to make adjustments to the campaign strategies and activities to improve the campaign's overall effectiveness; and 3) to evaluate whether the campaign interventions have had an positive impact on the outlined goals and objectives. The M&E plan includes a set of indicators that will be used for tracking progress and impact of the campaign, the data sources, the data collection plan, plans for data reporting, disseminating and use, and lastly the plan for evaluation the campaign.

III. M&E Framework for Safe Motherhood Campaign

The monitoring and evaluation (M&E) plan for the Safe Motherhood Campaign is based upon the goals and intermediate objectives of the campaign and the strategies and activities designed in order to achieve them. Together, the goal, objectives, strategies and activities form the M&E Framework for the Safe Motherhood campaign. This framework serves as the foundation for the M&E plan, as it outlines specifically how the activities and strategies of the campaign will lead to changes in knowledge, attitudes, self-efficacy and ultimately to changes in behavior. The overarching goal of the campaign is to change safe motherhood behaviors with the aim of contributing to a reduction in maternal mortality in Zambia, from 591 to 162 per 100,000 live births in 2013.

The six behavioral goals of the Safe Motherhood campaign are as follows:

1. To increase the percentage of women of reproductive age who use a modern method of family planning by 15% (from 32.7% to 47.7%);
2. To increase the percentage of pregnant women initiating antenatal care services (FANC) before 16 weeks by 20% nationwide;
3. To increase the percentage of pregnant women who complete at least 4 antenatal care visits by 20% nationwide;
4. To increase the percentage of pregnant women who have created a birth plan by 40% (baseline TBD)
5. To increase the percentage of pregnant women delivering in a facility by 25% nationwide (from less than 50% to 75%); and
6. To increase the percentage of women who receive three post-partum check-ups (6 hours, 6 days and 6 weeks) by 25% (baseline TBD).

The objectives of the campaign are organized by the specific health sub-topic area under the campaign, which include: antenatal care, family planning, delivery care and post-partum care. These objectives focus on the intermediate outcomes that we would expect to see the campaign contribute towards achieving. These include changes in knowledge, attitudes, beliefs and intentions. These are the outcomes we would expect to see prior to changes in behavior (refer to the six goals of the campaign).

Antenatal Care

1. To increase the percent of pregnant women who have planned for transport to a health facility for antenatal care and delivery care.
2. To increase the percent of women of reproductive age who believe that there is value in initiating ANC early in pregnancy.
3. To increase the percent of women of reproductive age who associate taking an HIV test during pregnancy with having a healthy baby.
4. To increase the percent of couples who discuss the HIV test and its implications.
5. To increase the percent of pregnant women who can identify at least three danger signs in pregnancy and labor.
6. To increase the percent of women of reproductive age who know that pregnancy does carry special risks that require care from trained health providers.
7. To increase the percent of men who support their wives completing all four ANC visits and delivering in a facility.
8. To increase the percent of pregnant women who are satisfied with the quality of care provided at the health clinic during ANC visits.
9. To Increase percent of women who believe that all ANC visits are worthwhile.

Family Planning

1. To increase the percent of women of reproductive age who associate practicing FP with staying healthy and having healthy children
2. To increase the percent of women of reproductive age who believe that modern contraception is safe.

3. To increase the percent of women of reproductive age who know where to access FP.
4. To increase the percent of women of reproductive age who know at least three options for family planning.
5. To increase the percent of men who believe that they have a role in family planning.
6. To increase the percent of men who support their partner/wife in practicing family planning.

Delivery Care

1. To increase the percent of women of reproductive age who report feeling confident that they can seek and obtain the necessary care to deliver a healthy baby.
2. To increase the percentage of pregnant women who believe that a facility based delivery is compatible with traditional ways.
3. To increase the number of pregnant women who believe that a health facility delivery is safer than a home delivery.
4. To increase the percent of men who believe that they have a role in pregnancy and childbirth.
5. To increase the percent of mothers and mothers-in-law of pregnant women who say they support the pregnant women in delivering in a facility.
6. To increase the percent of couples who have completed a birth plan and saved money for transportation to health facility for delivery.

Post-partum Care

1. To increase the percent of women who believe it is the woman as well as the newborn that require attention from a trained health provider immediately after birth.
2. To increase the percent of women who know how many visits to the health clinic they should plan for during pregnancy and after birth.

The strategies and activities outlined in the Safe Motherhood Campaign Strategy and Safe Motherhood Implementation Plan (Annex A and B), demonstrate how each strategy/activity will contribute towards achieving the (above) objectives and goals of the campaign.

IV. Monitoring Plan

M&E Performance Indicators

The M&E system for the Safe Motherhood Campaign consists of indicators for tracking inputs, campaign processes and outputs, and intermediate and long-term outcomes. The set of indicators will be used to track the progress of the implementation of the campaign, to make any necessary improvements to the campaign and to evaluate whether the campaign achieved its objectives and had the intended impact on both the expected intermediate and long-term outcomes.

Input indicators will measure the amount of resources that are put into implementing and carrying out the campaign interventions, including the human, financial and material resources.

Process indicators will measure the basic processes (e.g. campaign was developed based on formative research) used for implementing the campaign. Process indicators will be collected in the campaign tracking database and will be standard across all campaigns. The process indicators that will be collected:

- Number of districts reached with specific activities
- Number of communication channels used
- Campaign developed based on existing evidence and/or formative research
- Campaign developed according to minimum GRZ standards/guidelines
- Campaign reviewed by the IEC/BCC Technical Working Group
- Campaign received private sector support

Key characteristics of the campaign, including the health topics and sub-topics covered, the target audiences, and the length of the campaign will also be recorded in the campaign tracking database.

Output indicators will be used to measure whether campaign activities are implemented as planned and whether the campaign is reaching the target audience.

Outcome indicators will measure changes in knowledge, attitudes, beliefs, intentions and lastly, behavior. Table 1 provides the comprehensive list of indicators that will be used to monitor and evaluate the campaign.

Data Collection and Dissemination Plan

Data will be collected using a number of data collection tools developed by CSH, which include both paper based and electronic forms. All data will be entered into the campaign database for data aggregation, analysis and reporting.

Data will be collected for the indicators according to the frequency outlined in Table 1. Specifically for project partners (Civil Society Organizations) implementing activities at the community level, data will be collected on a monthly basis. This data will be reviewed and analyzed by the CSH M&E team on a quarterly basis and shared with the CSH technical team.

Data will be reported on a semi-annual and annual basis, according to reporting requirements. Semi-annual and annual results will be shared with GRZ (NAC), CSH management, and USAID to

track progress and make any necessary programmatic changes to improve the implementation of the campaign.

Data Collection Tools

The following data collection forms/tools will be used to collect data for monitoring and evaluating the Safe Motherhood Campaign:

1. Monitoring form for Safe Motherhood Products: This form will be used to track the production and distribution of the various materials/products produced for the Safe Motherhood Campaign, including products distributed to other partners working in collaboration with CSH.
2. Civil Society Organization (CSO) Data Collection Forms: These forms will be used by CSO's to monitor their various activities, including community-based, small group and individual level activities and interventions. This will also include forms to track people trained and the number of products/materials produced and disseminated.
3. Rapid Survey Questionnaires: The survey questionnaire will be used to monitor the percent of the population exposed to the Safe Motherhood campaign. It will be administered approximately twice a year. The questionnaire will assess exposure to the various broadcast and small media components of the campaign.

V. Evaluation Plan

An external impact evaluation of the Safe Motherhood campaign will be carried out by the National Opinion Research Center (NORC) at the University of Chicago. The evaluation will use a randomized control trial design and will be targeted to specifically assess the impact of a package of health center and community level interventions on both the intermediate level outcomes (knowledge, attitudes, beliefs, intentions, etc.) and long-term outcomes (behavior). The aim of the evaluation will be to not only evaluate whether the intervention package generates a positive impact, but also the magnitude of the impact and the cost-effectiveness of the intervention.

The specific package of activities that will be evaluated at the health center and community level are: the provision and use of job aids and communication materials by civil society organizations (CSOs); the provision and use of job aids and communication materials by health centers; and CSO activities targeted at reaching and engaging men with messages related to safe motherhood.

The evaluation will draw from data at both the household and health facility levels. Specifically, data collection will include health center service statistics, random (unscheduled) visits to health facilities to conduct exit interviews with clients and random checks on the availability and use of communication materials provided to the health centers, and lastly, household surveys which will be used for measuring both intermediate and long-term outcomes.

A detailed evaluation protocol will be developed by NORC in March 2012 and included as an annex when available within the M&E plan.

Table 1. Monitoring and Evaluation Indicators for Safe Motherhood Campaign

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
Campaign Inputs				
Annual financial resources spent on mass media activities (TV, Radio, SMS)	Disaggregated by: • TV/Radio/SMS	Review of CSH financial reports	CSH financial reports	Annual
Financial resources spent on materials production	N/A	Review of CSH and CSO financial reports	CSH and CSO financial reports	Annual
Financial resources spent on IPC activities (individual, small-group, family and community-based activities)	N/A	Review of CSH and CSO financial reports	CSH and CSO financial reports	Annual
Campaign Processes				
Health topic and sub-topics of campaign	N/A	Review of campaign strategy and implementation plan	Safe Motherhood Campaign strategy and implementation plan	Annual
Target audience of campaign	N/A	Review of campaign implementation plan, campaign activity reports	Safe Motherhood implementation plan, campaign activity reports	Annual
Number of communication channels used by campaign [CSH PMEP Indicator 1.3.1]	*Disaggregated by*: • Type of communication channel	Review of campaign activity reports and monitoring calendar	Campaign activity reports, monitoring calendar reports	Annual
Formative research conducted for campaign [CSH PMEP Indicator 2.2.2]	N/A	Review of formative research report for campaign	Formative research report	Once
Campaign developed based on existing evidence and/or formative research [CSH PMEP Indicator 1.3.2]	*Evidence-based*: health communication campaigns and activities that have messages and materials designed using research findings. *Formative research*: the initial research that is conducted in a particular technical area to inform the	Review of campaign strategy and implementation plan	Safe Motherhood Campaign strategy and implementation plan	Once

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
	development of a campaign			
Campaign developed according to GRZ minimum standards/guidelines [CSH Indicator 0.2]	*GRZ minimum standards/guidelines*: Minimum GRZ standards refers to national guidelines on development and pretesting of messages and materials	Review of campaign strategy and implementation plan against GRZ minimum standards/guidelines	Campaign strategy document, campaign implementation plan	Once
Campaign reviewed by the IEC/BCC Technical Working Group (TWG) [CSH PMEP Indicator 3.1.1]	*Reviewed by IEC/Malaria TWG*: Campaign is reviewed by the IEC/BCC TWG using established standard guidelines *IEC/ Malaria Technical Working Group*: Technical working group that meets to coordinate and review health communication interventions in Zambia.	Review of IEC/ *Malaria* TWG reports or meeting minutes	IEC/ *Malaria* TWG report and/or meeting minutes	Once
Campaign received private sector support [CSH PMEP Indicator 3.2.1]	*Disaggregated by*: • Type of support	Review of campaign reports	Campaign reports	Annual
Monitoring Implementation (Campaign Outputs)				
Number of promotional advertisements aired per week	*Disaggregated by*: • Communication channel (TV, radio) • Program (Change Champion Chief documentary, Journey to Becoming a Parent)	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of radio spots	*Disaggregated by*:	Review of campaign	Campaign	Monthly

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
for women pre-pregnancy on family planning aired per week	• Version of spot • Language • Radio channel	media plans and media monitoring calendar forms	media plan, media monitoring calendar form	
Number of radio spots for general public aired per week	*Disaggregated by*: • Version of spot • Language • Radio channel	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of radio spots for men aired per week	*Disaggregated by*: • Version of spot • Language • Radio channel	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of district-specific radio spots aired per week	*Disaggregated by*: • District • Radio channel	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of health centers using counseling tools (checklist and FP materials)	*Disaggregated by:* • Urban/rural	Health facility survey	Health facility survey	Monthly
Number of times Journey to Becoming a Parent documentary is aired per month	*Disaggregated by*: • Part (Documentary has 4 different parts) • Communication channel (TV and Radio)	Review of CSH activity completion reports and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of times Change Champion/Champion Chief Documentary is aired per month	*Disaggregated by:* • Province	Review of CSH activity completion reports and monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of SMAGs and/or community counselors trained in counseling on safe motherhood messages	*Disaggregated by*: • Type (SMAG or Health worker) • Province • Sex of trainee	Review of CSH activity completion reports activity completion reports	CSO activity completion reports	Monthly
Number of health workers trained in use of materials from Safe Motherhood	*Disaggregated by*: • Province • Sex of trainee	Review of CSH activity completion reports activity completion reports	CSO activity completion reports	Monthly
Number of materials placed and/or mounted	*Disaggregated by*: • Type of material (posters, flyers, bumper stickers, billboards, pole lights, branding placed on walls or buses)	Review of CSH and CSO activity completion reports	CSH and CSO activity completion reports	Monthly

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
Number of materials distributed	*Disaggregated by*: • Type of material (leaflets, folders, caps, t-shirts, chitenges, bandanas, telescopic flags, a-frames, flyers, program kits, job aids, pictorial birth plans, fact sheets, documentaries...)	Review of CSH and CSO activity completion reports	CSH and CSO activity completion reports	Monthly
Number of health newspaper inserts produced and disseminated	*Disaggregated by*: • Type of health newspaper insert • Newspaper	Review of campaign media plans, media company monitoring	Campaign media plan, media company monitoring reports	Monthly
Monitoring Reach of Campaign (Campaign Outputs)				
Percent of audience who recall (spontaneously and aided/prompted) seeing and/or hearing about the Safe Motherhood campaign	*Disaggregated by*: • Spontaneously vs. aided/prompted • Sex • Urban/rural • Channel	Rapid population-based survey	Rapid survey report	Every 4 months
Percent of audience who recall a specific component/characteristic (spontaneously and aided/prompted) of the Safe Motherhood campaign	*Disaggregated by*: • Spontaneously vs. aided/prompted • Sex • Urban/rural • Channel	Rapid population-based survey	Rapid survey report	Every 4 months
Percent of audience who recall hearing or seeing (spontaneously and aided/prompted) a specific health message from the Safe Motherhood campaign	*Disaggregated by*: • Spontaneously vs. aided/prompted • Sex • Urban/rural • Channel	Rapid population-based survey	Rapid survey report	Every 4 months
Number of individuals reached through IPC activities	*IPC:* Interpersonal communication activity such as one on one, small-group, family or community-based activity/intervention *Disaggregated by*: • Sex • Topic Area	Review of CSO program records and reports	CSO program records and reports	Monthly
Intermediate Outcomes (Knowledge, Attitudes, Self-efficacy, and Behavioral)				
Antenatal Care				

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
Percentage of pregnant women who are satisfied with the quality of care provided at the health clinic during their last ANC visit	*Disaggregated by:* • Urban/rural	Client exit interview conducted at health facility	Client exit interview reports	Baseline and Endline
Percentage of women who believe that all four ANC visits are worthwhile	*Disaggregated by:* • Urban/rural	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of women of reproductive age (aged 15-49) who believe that there is value in initiating ANC early in pregnancy	*Disaggregated by:* • urban/rural	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of women of reproductive age (aged 15-49) who associate taking an HIV test during pregnancy with having a healthy baby	*Disaggregated by:* • Urban/rural	Household Impact survey	Household Impact Survey report	Baseline and Endline
Percentage of pregnant women who can identify at least three danger signs in pregnancy and labor	*Disaggregated by:* • Urban/rural	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of women of reproductive age (aged 15-49) who know that pregnancy does carry special risks that require care from trained health providers	*Disaggregated by:* • Urban/rural	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of male partners aged 15-59 who support their wife/partner completing all four ANC visits	*Disaggregated by:* • Urban/rural	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Family Planning				
Percentage of women of reproductive age (aged 15-49) who associate practicing FP with staying health and having healthy children	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of women of reproductive age (aged	*Disaggregated by:*	Household Impact Survey	Household Impact Survey	Baseline and Endline

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
15-49) who know where they can access FP	• Urban/rural • Wealth quintile • Region		report	
Percentage of women of reproductive age (15-49) who believe modern contraception is safe	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of women of reproductive age (aged 15-49) who say they understand at least 3 options for family planning	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of men aged 15-59 who believe that they have a role in family planning	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of male partners aged 15-59 who support their wife/partner in practicing family planning	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Delivery Care				
Percentage of women of reproductive age (aged 15-49) who report feeling confident that they can seek and obtain the necessary care to deliver a healthy baby	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of pregnant women who believe that a facility based delivery is compatible with traditional ways	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of pregnant women who believe that a facility based delivery is safer than a home delivery	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact survey report	Baseline and Endline
Percentage of men aged 15-59 who believe that they have a role in pregnancy and childbirth	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact survey	Household Impact survey report	Baseline and Endline
Postpartum Care				
Percentage of women who think it is the	*Disaggregated by:*	Household Impact Survey	Household Impact survey	Baseline and Endling

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
woman as well as the newborn who require attention immediately after birth	• Urban/rural • Wealth quintile • Region		report	
Percentage of women of reproductive age (aged 15-49) who know how many visits to the health clinic they should plan for during pregnancy and after birth	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact survey report	Baseline and Endling
Long-Term Outcomes (Campaign Outcomes)				
Antenatal Care				
Percentage of pregnant women who have planned for transport to facility for ANC and delivery	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of women attending an ANC visit accompanied by their partner	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Review of health facility records	Health facility records	Monthly
Percentage of couples who have discussed the HIV test	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Percentage of pregnant women who have initiated antenatal care services before the first 16 weeks of pregnancy	*Disaggregated by:* • Urban/rural • Region	Review of health facility records	Health facility records	Monthly
Percentage of pregnant women who complete at least 4 antenatal care visits	*Disaggregated by:* • Urban/rural • Region	Review of health facility records	Health facility records	Monthly
Family Planning				
Percentage of women of reproductive age (women aged 15-49) who use a modern method of family planning	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline

Indicator	Definition	Methodology/Data Collection Method	Data Source	Frequency of Collection
Delivery Care				
Percentage of pregnant women who delivered in a health facility	*Disaggregated by:* • Urban/rural • Region	Review of health facility records	Health facility records	Monthly
Percentage of pregnant women who have created a birth plan and saved money for transportation to health facility for delivery	*Disaggregated by:* • Urban/rural • Wealth quintile • Region	Household Impact Survey	Household Impact Survey report	Baseline and Endline
Postpartum Care				
Percentage of women who receive a post-partum check-up within 48 hours after delivery	*Disaggregated by:* • Urban/rural • Region	Review of health facility records	Health facility records	Monthly
Percentage of women who conduct post-partum visits	*Disaggregated by:* • Urban/rural • Time of visit (at 6 hours, 6 days and 6 weeks)	Review of health facility records	Health facility records	Monthly

Annex A: -Safe Motherhood Campaign Strategy

I. Background

Zambia as a nation has made extensive progress in recent years towards achieving the Millennium Development Goals. The Zambian health system continues to improve and access to services is increasing. However, a number of health issues persist. One critical issue is maternal mortality. Zambia's maternal mortality ratio of 591/100, 000 live births[5] ranks among the highest in the world. This mortality is attributable to a number of complex and interwoven factors. Low contraceptive use in Zambia has resulted in high fertility trends over the years, with a current average fertility rate per woman of 6.3[6]. Only about half of pregnant women initiate antenatal care by 5.1 months of gestation,[7] preventing the opportunity for early detection of danger signs and adequate management of maternal complications.

Half (52%) of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5% as compared to 15.7%). But even when a woman delivers in a facility, utilization of postpartum care services is extremely low. Nationwide, more than half (51%) of women do not receive any postnatal care.[8]

To directly address these challenges, the Government of the Republic of Zambia (GRZ), as party to the CARMMA framework, is launching aggressive efforts in both service delivery and creation of demand for services with the goal of reducing its MMR to 162/100,000 by 2015.

In support of this effort, the United States government, through its Communication Support for Health (CSH) project, is supporting the GRZ in launching a national "campaign to promote safe motherhood." CSH and the GRZ, together with a number of implementing stakeholders, have identified several key areas where demand creation and individual and collective behavior change are critical to the success of the initiatives. Specifically, women should choose and practice a modern contraception method prior to their first and between subsequent pregnancies; once pregnant, women and their partners need to understand the importance of and seek early antenatal care, complete at least four ANC visits prior to delivery, plan for and deliver their baby in a facility, and seek adequate post-partum follow-up at prescribed intervals after the baby is born (6 hours, 6 days and 6 weeks). The campaign to promote these behaviors will run from 2012 until at least 2014.

II. Process

Work on this campaign began in mid-2011 with consultative meetings with all partners working in maternal/reproductive health in the country in order to determine the overall framework for the campaign and the key issues that will be addressed. Formative research and a literature review of existing research were conducted before the final strategy for the campaign was developed. A design workshop was held outside Lusaka in early November 2011 to decide on the main activities and communications products the campaign would support and subsequent follow-up meetings were held with additional partners to ensure consensus on these concepts.

[5] Zambia Demographic and Health Survey, 2007
[6] World Bank Development Indicators, 2009
[7] Zambia Demographic and Health Survey, 2007
[8] Zambia Demographic and Health Survey, 2007

The campaign will be launched in late March of 2012

III. Vision:

The "NAME" campaign is a new communications initiative designed to run for two years, starting in March of 2012. It will directly support efforts under the pan-African CARMMA framework and will also align closely with USAID's Saving Mothers Lives program in the four districts where SML will focus. The campaign will take a comprehensive approach and will work at many levels of society to ensure that the results as described below are achieved.

IV. Impact

The lasting impact that this campaign seeks to have is ultimately a contribution to the GRZ goal of reducing maternal mortality in Zambia from 591 to 162 per 100,000.

V. Goals

The goals of this campaign are a set of six key behaviors practiced by specific people that individually and collectively will translate into impact. These goals are:

- To increase the percentage of women who use a modern method of family planning by 15% (from 32.7% to 47.7%)
- To increase the percentage of women initiating antenatal care services (FANC) before 16 weeks by 20% nationwide
- To increase the percentage of women who complete at least 4 ANC visits by 20% nationwide
- To increase the percentage of women who have created a birth plan by 40% *(no baseline measured in DHS; will be measured by CSH baseline)*
- To increase the percentage of women delivering in a facility by 25% nationwide (from less than 50% to 75%)
- To increase the percentage of women who receive three post-partum check-ups (6 hours, 6 days and 6 weeks) by 25% (*baseline data measured for 1 post-partum checkup received within two days (39%). Baseline for this specific goal will be established by CSH baseline)*

The time frame for achieving these objectives is two years, the life of the campaign. Baseline figures given here are from the 2007 Zambia Demographic and Health Survey, but will be updated using a baseline that will be conducted by CSH in the initial stage of the campaign development.

These specific behaviors were chosen at the exclusion of others, including nutrition-related behaviors such as utilization of iron folate or increasing daily caloric intake, and adolescent reproductive health behaviors such as delayed sexual debut, because other campaigns (the MOH/CSH 1000 days campaign for example) will cover these behaviors. Further, selecting these most critical behaviors will ensure the campaign stays focused for maximum impact.

VI. Audience Groups

Although the primary audience group for promotion of all of the key behaviors are pregnant women of any age, secondary target audience groups include other relevant family and community members, namely Safe Mother Action Groups (SMAGs), partners of pregnant women, traditional leaders, extended family members of pregnant women, and the community at large. Additionally, because the rates of facility based deliveries and complete antenatal care attendance are much higher in urban areas, much of the focus for this campaign will take place

in rural areas through innovative strategies to reach women with less access to traditional media. However, urban women will still be exposed and therefore benefit from the many mass media aspects of the initiative.

VII. Summary of Research Findings

In an effort to understand the context for promoting these behaviors, CHS in partnership with the MOH conducted an extensive literature review on existing research on these practices as well as its own formative research activity. Key findings are summarized below by topic.

Antenatal care

Knowledge about antenatal care is high; specifically participants report knowing that they should plan for birth, the possible risks of malaria during pregnancy and the necessity of knowing one's HIV status during pregnancy. Women also know some of the most common danger signs during pregnancy, including bleeding, vomiting, swelling of feet and legs, dizziness and/or shortness of breath, reporting that a woman experiencing these symptoms should be rushed to a health facility.

In general, antenatal care is seen as beneficial because it contributes to safe delivery; especially in cases of pregnancy complications. This perception is reflected in the very high rates of women accessing at least 1 antenatal care visit (94%). However, only 60% of women attend the recommended 4 minimum ANC visits and only half initiate care before their fifth month[9]. Most women indicate that the major reason they do not seek antenatal care earlier is to reduce the number of times that they have to attend, and therefore pay transport to, the antenatal clinic. Others believe that it is not possible for health care providers to provide any information on the baby during the early stages of pregnancy and as such, there was no real reason to attend until the baby can be felt. Others see antenatal care as only for use to handle complications in pregnancy and there are generally fewer visible/noticeable complications during early pregnancy than in later stages.

Among the services received by pregnant women at the antenatal care visit are check-ups for weight and blood pressure and an external physical exam to determine the condition of the baby. Generally, the quality of health care services is reported to be adequate and seemed to be measured by the type of reception received at the health center or whether one was able to find the necessary answers to questions or help for a problem, however many women also register a dissatisfaction with services stemming from a long wait on queues before being attended to; or the lack of adequate attention from health care providers.

Delivery

Nearly half of all pregnant women deliver from home, either unintentionally or intentionally. The reasons for this include women failing to recognize the signs of labor in time; being embarrassed of not being able to buy the items needed to prepare for the birth of the baby; and not understanding or believing the risks of home delivery. Some are unable to pay for transportation or, in some cases, find transportation on short notice when labor starts. Staff shortage at clinics is also a barrier to facility delivery, as many women report having heard or experienced stories

[9] Zambia DHS 2007

where a traditional birth attendant who accompanies the mother to the facility ends up delivering her there because there is no skilled attendant. UNFPA estimates 605 additional trained midwives are necessary in Zambia to achieve 95% coverage of skilled attendants at delivery. Currently, nationwide, there are 0.8 medical professionals (doctors or nurses) per 1000 people. These systems issues directly influence a family's motivation to expend the financial and emotional effort of delivering in a facility.

Postpartum Care

As mentioned, utilization of post-partum care is very low. Women are intently focused on the newborn in the post-partum period and as such, do not prioritize their own care-seeking, especially when no problems are evident. The Ministry of Health has established a policy for post-partum care, recommending that a woman be checked through a physical exam at 6 hours, 6 days and 6 weeks post-partum. Research indicates that even for women delivering in facilities, many leave well before 6 hours, if the delivery itself was uncomplicated. Further, few women seek out a skilled attendant for the 6 day exam. Reasons given include a lack of awareness about the necessity of this exam as well as cultural beliefs preventing a mother from leaving the house with a newborn in the first month of life. Many women do seek the 6 week post-partum exam, because they are already going to the clinic to have their child immunized.

Family Planning

The research is consistent in finding that knowledge about use and benefits of contraceptives was fairly high, although the contraceptive prevalence rate for the country is still low at 41%[10] . The benefits of family planning reported by women included child spacing; limiting the number of children in a family to enable parents to care for all children adequately and to allow mothers an easier life. The most commonly known and used contraceptives in Zambia are the pill, injectables/Depo-Provera, and condoms. Contraceptives are generally available either through health facilities or pharmacies, although stock-outs are not uncommon.

Most of the information on modern contraceptives was obtained from health care providers and community health workers, and women say that this information is generally understood and accepted by the community, however many women choose not to use family planning because of fear of side effects—both accurate side effects and false ones such as cancer and infertility. Additionally, some women report not using contraceptives because the health provider herself doubts their efficacy or safety.

The women who do use modern contraceptives say that they do so because their benefits were perceived to override the side effects. This was further enhanced by the ability to change contraceptives for ones that had fewer side effects. The choice of contraceptives was also based on how frequent and long the stock-outs were for that particular product. Decision making on the use of modern contraceptives was primarily a prerogative of the woman, with input from husbands. In some cases, despite a husband's refusal to use contraceptives, women choose to continue or initiate use of a method that does not require the husband's knowledge such as injectables. Some women use traditional contraceptives. However, many do not as there is a general perception that traditional methods are less effective and not easily accessible.

[10] UNICEF Country Statistics, Zambia

Male involvement in issues of safe motherhood

Many men feel that pregnancy and childbirth is the domain of the woman. Although some do attend antenatal care with their partners, most do not and are not involved in saving money for transportation for ANC and delivery. Further, some women report that their partners are interested in them attending the ANC visit to get the HIV test, but they use the test results of the pregnant woman as a proxy for their own, rather than also getting tested.

Traditional leader involvement in issues of safe motherhood

In some districts in Zambia, the chief has taken it upon himself to issue policies whereby every woman delivers in a facility, with a penalty or fine imposed for those who do not. Many chiefs keep birth and death records and view themselves in being able to play a strong role in the decisions people make in their life, including intimate moments such as childbirth. These success stories and the influence that these leaders can have on the decisions people make are being leveraged by CARMMA. Meetings have already been held to bring together chiefs to discuss how they might be involved.

Channels for accessing information on safe motherhood

Information on issues during pregnancy, delivery and post-partum was generally accessed through members of the Safe Motherhood Action Group (SMAGs) or other community volunteers at community level. Many organizations are currently working across Zambia to strengthen these various groups, but in many cases, they are still unequipped with the tools and training necessary to execute their jobs. People report the greatest level of trust in information obtained from a trained professional such as a nurse or doctor, and access information at clinics when there for other reasons, although the time that the health provider has to spend counseling each pregnant women is very limited. Information is also obtained from peers in the community such as female parents, neighbors and friends and many myths and misconceptions about facility delivery, family planning, and post-partum issues are reinforced by perceived social norms and collective opinions.

Synthesis

Using a model of behavior change called “Opportunity/Ability/Motivation” which is depicted in Appendix 1, the following critical barriers to the key behaviors were extracted from the research:

- Fear of HIV test as part of ANC
- Disbelief in benefit of early ANC
- Fear of process/experience of facility delivery
- Disbelief that facility delivery is necessarily safer
- Weak social support/involvement of families, leaders, etc… (and a corresponding lack of willingness to allocate financial and emotional resources to care-seeking)
- Transportation/access issues
- Perception of lack of quality in clinics
- Pregnant women perceive quality of care and treatment by health personnel to be inadequate
- Lack of preparation/birth planning
- Fear of family planning side-effects
- Lack of knowledge on diversity of family planning options

VIII. Communication Objectives

The communication objectives for this campaign will specifically address these key barriers. The communication itself will:

CRITICAL BARRIER	COMMUNICATION OBJECTIVE	INDICATORS
• Fear of HIV test as part of ANC • Disbelief in benefit of early ANC • Fear of process/experience of facility delivery • Disbelief that facility delivery is necessarily safer	• Convince women of importance /reasoning for early initiation of ANC, completing all 4 behaviors • Demystify what happens in ANC, during facility delivery and postpartum • Address concerns around HIV test—how and when to get your partner involved, what is the test like, what happens if you are positive, etc…	▪ Increase women who report feeling confident that they can seek and obtain the necessary care to deliver a healthy baby by X% ▪ Increase percentage of pregnant women who can identify at least three danger signs in pregnancy and labor by X% ▪ Increase percentage of pregnant women who believe that a facility based delivery is compatible with traditional ways by X% ▪ Increase number of pregnant women who say that delivery in a facility is safer than delivery at home by X% ▪ Increase number of pregnant women who agree that taking an HIV test is a critical step to ensuring a healthy baby by X% ▪ Increase percentage of couples who discuss the HIV test and its implications by X% ▪ Increase number of women who say that pregnancy does carry special risks that need extra care from trained professionals from X% to X%
• Weak social support/involvement of families, leaders, etc… (and a corresponding lack of willingness to allocate financial and emotional resources to care-seeking)	• Increase involvement of men in supporting women to practice key behaviors • Increase social support for key behaviors • Motivate “community change champions” to support mothers in seeking services from ANC to family planning	• Create a change champion in X% of communities • Increase percentage of men who believe that they have a role in family planning, pregnancy and childbirth by X% • Increase percentage of men who say they support their wives completing all 4 ANC visits and delivering in a facility by X% • Increase percentage of men who support partners/wives in practicing family planning from X to X% • Increase percentage of mothers and mothers-in-law of pregnant women who say they support the pregnant woman delivering in a facility by X%
• Perception of lack of quality in clinics • Pregnant women perceive quality of care and treatment by health personnel to be inadequate	• Improve attitude/quality of counseling skills on safe motherhood issues by health worker • Change perception of quality at clinics • Increase quality of IPC messages in communities	• Increase number of women who rate their interaction with the health worker at the health clinic for ANC visits as excellent from X% to X% • Increase number of women who report the opinion that all ANC visits are worthwhile from X% to X% • Increase percentage of health workers who use the counseling materials with women by X% • Increase percentage of SMAGs who say they have appropriate tools for doing their job by X%

• Transportation/access issues • Lack of preparation/birth planning	• Increase awareness of necessity of birth planning and what birth planning means	• Increase number of couples who have completed a birth plan including transportation savings from X% to X%
• Fear of family planning side-effects • Lack of knowledge on diversity of family planning options	• Address concerns and fear of side effects of family planning • Increase knowledge on options for family planning	• Increase percentage of women who believe modern contraception is safe from X to X% • Increase percentage of women who say they understand at least 3 options for family planning from X% to X%

IX. Activities, Communications Tools and Key Messages

In order to effectively deliver on these communications objectives and address the critical barriers, the MOH and CSH will carry out a broad range of activities. All activities will be nationwide, but they will be conducted at various levels: in communities, in health facilities and via mass media—including mobile. Some, such as mass media, CSH will implement directly in partnership with the GRZ and with support from the Technical Working Group and other USG partners. Some activities, however, are activities already being programmed and planned by other implementing agencies. In these cases, CSH's role will be one of providing communications tools and resources to support those activities. **CSH understands that many of these tools are already in development or planned to be developed by partners. Through the GRZ/MOH, CSH will work with all partners to ensure that no products are duplicated and that the necessary tools are adapted and duplicated.**

The activities, products, intended user and audience for the product are described in the table below, organized by which specific communication objective they will contribute to achieving.

COMMUNICATION OBJECTIVE	ACTIVITIES	COMMUNICATION PRODUCTS	USER/AUDIENCE
• Convince women of importance /reasoning for early initiation of ANC, completing all 4 behaviors • Demystify what happens in ANC, during facility delivery and postpartum • Address concerns around HIV test—how and when to get your partner involved, what is the test like, what happens if you are positive, etc…	**Community Level:** • Use SMAGs and other community volunteers to counsel and educate women on family planning options, the necessary care to take once a women gets pregnant, the risks of pregnancy (early through post-partum period) and how to avoid them (in groups and house-to-house) as well as to reward families who are "safe". **Clinic Level:** • Use waiting rooms to air "Journey to Becoming a Parent" 4-part series videos or radio programs on different aspects of pregnancy, delivery and post-partum care • Use health workers to provide additional counseling and explanations of what they are doing, why and what the mother should be	**Community Level** • Job-aid "tool-kits" for SMAGs with flip charts and pictorial birth plan forms • Certificates for "Safe Families" as recognition of a successful facility delivery and all post-partum follow up visits **Clinic Level:** • Journey to becoming a parent documentary • Counseling checklist • Posters	User=SMAG or other CHW in communities, health worker in clinics Audience = Women pre-pregnancy, pregnant women, extended families

COMMUNICATION OBJECTIVE	ACTIVITIES	COMMUNICATION PRODUCTS	USER/AUDIENCE
	thinking about • Produce low-text posters to reinforce messages (or where there is no radio/TV capability) **Mass Media** • Air national TV and radio documentaries "Journey to Becoming a Parent" 4-part series. • Use community radio to foster discussions and provide depth	 **Mass Media** • Journey to becoming a parent documentaries (TV and radio) • Discussion guides for community radio stations	
• Increase involvement of men in supporting women to practice key behaviors • Increase social support for key behaviors • Motivate "community change champions" to support mothers in seeking services from ANC to family planning	**Community Level:** • Involve traditional and other leaders in a "Change Champions" program • Conduct outreach/meetings with men in gathering places or workplaces **Clinic Level** n/a **Mass Media Level:** • Champion chiefs documentary and associated road show • Province-specific radio ads featuring local chiefs • Becoming a parent documentary • Becoming a parent radio documentary • Newspaper inserts for leaders • Newspaper inserts for men • Fliers/pamphlets/billboards for men on becoming a father and on family planning	**Community Level** • Materials for chiefs interested in becoming a Champion Chief • "Becoming a Father" fact sheets • Family Planning—the man's role fact sheets **Clinic Level** n/a **Mass Media Level:** • Champion chiefs documentary • Province-level radio ads for chiefs • Becoming a parent 4-part TV and radio documentary • Print materials for men (fliers, newspaper, etc…)	Change champions use materials to guide goal selection and activities (talks, discussion forums, etc…); Audience is chiefs themselves, other leaders, and ultimately their communities. Community volunteers or SMAGs use materials for men to provide outreach, structure conversations with men; audience is ultimately men
• Increase quality of IPC messages in communities • Improve attitude/quality of counseling skills on safe motherhood issues by	**Community Level:** • Provide support materials to SMAGs and other volunteers • Provide quality IPC job aids to SMAGs and other	**Community Level** • Support items for SMAGs (vests and bags) • SMAG job-aid toolkit	User & Audience: SMAGs/other Community Volunteer

COMMUNICATION OBJECTIVE	ACTIVITIES	COMMUNICATION PRODUCTS	USER/AUDIENCE
health worker • Change perception of quality at clinics	volunteers **Clinic Level** • Create counseling checklist for health worker/provider to use on issues of safe motherhood **Mass Media Level:** • Radio ads targeted to health workers promoting their role in safe motherhood	 **Clinic Level** • Counseling checklist **Mass Media Level:** • Motivational radio ads (2 versions) for health workers	
• Increase awareness of necessity of birth planning and what birth planning means	**Community Level:** • Use SMAGs and other CHVs to distribute and help couples use picture-based birth plans to think through and plan all activities around getting pregnant, being pregnant and having the baby **Clinic Level:** • The same birth plan will be usable by health workers to counsel mothers-to-be on planning **Mass media level:** • As part of radio and TV documentaries, the steps to plan for birth will be reinforced • Separate radio announcements	**Community Level** • Picture-based birth plan **Clinic Level** • Picture-based birth plan **Mass Media Level:** • One 60-second radio spot on how to plan for birth	User: SMAG or other volunteer in communities, health worker in clinics Audience: ultimately the woman and her partner/extended family
• Address concerns and fear of side effects of family planning • Increase knowledge on options for family planning	**Community Level** • Use SMAGs and community-based distributors of FP services to offer counseling to women before and between pregnancies • Work through schools to reach girls just before the average age of marrying to discuss what FP is, that it is safe and what options are there when they are ready • Work through traditional counselors to offer counseling on FP options and safety	**Community Level** • Counseling cards on FP (as part of job aid toolkit for SMAGs) • Fact sheet/ brochure for discussing FP options with women	User=SMAG or other community volunteer, traditional counselor or teacher in communities, health worker in health facilities Audience: women before pregnancy and women in-between

COMMUNICATION OBJECTIVE	ACTIVITIES	COMMUNICATION PRODUCTS	USER/AUDIENCE
	Clinic Level • Use posters to dispel myths about safety of FP • Play 1st part of the journey to becoming a parent series, which will deal with family planning issues in waiting areas • Use health workers to provide counselors to women during pregnancy and immediately after on family planning **Mass Media Level:** • Journey to becoming a parent radio and TV series • Champion chiefs documentary series • Radio ads promoting family planning alone	**Clinic Level** • Posters • Documentaries **Mass Media Level:** • Documentaries • Radio adverts	pregnancies

X. Key Messages

The key messages for the campaign are divided by audience group. Note that all of these messages will not be communicated all the time. Depending on the purpose and audience for the specific product, one or more specific key messages will be highlighted.

Non-pregnant women of child-bearing age:

Adolescent girls and women who have not yet had children:

- A baby is a huge responsibility, one that will occupy you for the rest of your life. You have a choice to plan when you take that responsibility.
- Planning your family is safe; there are many options that work well for now, but will still let you have a baby when you are ready.

Pregnant women and other women of child-bearing age (who already have at least one child):

- Your body is well made for giving birth, but it needs to rest between pregnancies. Space your children at least 2 years apart.
- There are many safe methods—both temporary and permanent—that you can choose from. If you choose a temporary method, you can still have children when you stop using it.
- Although some people experience minor side effects with some methods, many people don't. IF you do, you can always change methods.
- Methods for family planning should always be available from your nearest health center or via a community drug distributor. These people can also help you figure out what is right for you. (customize this one based on each district's availability)

Pregnant women:

Message for pregnancy women are comprehensive, but specific and different for each stage of the pregnancy, delivery and post-partum period.

Overarching message concept:

Becoming a mother is an amazing process, but it is not without risks. You and your family have the power to reduce those risks. Lean on your partner, your friends and your family, and plan for a healthy and happy baby!

During pregnancy:

- Go for ANC as soon as you know you are pregnant
- At each ANC visit, you will learn a bit more about how your baby is doing. It is critical you go to as many as possible, try for at least 4

- At some ANC visits, you will get medicine, Fansidar, to make sure you and your baby don't get sick from Malaria. It is safe for you and baby—just take a bit of food with you to clinic to help it settle in your stomach.
- During your first visit, they will ask to do an HIV test. This test is important because if you are HIV +, you MUST know before you give birth, or you risk passing the disease to your baby. Plus, this way you can get treatment to ensure you are able to enjoy your baby for a long time.
- The HIV test is quick, easy and painless. You get your results right away and only you decide who else should know.
- Have your husband or partner go with you to the visit if possible—give them one of the fact sheets on becoming a father and talk to him about what you have learned here

Delivery:

- Women have been delivering babies forever—it is something we were meant to do, but sometimes problems happen. The baby can get stuck, or your body can start bleeding. In these cases, if you are at home, there is nothing to do. In a clinic, they can save you and the baby.
- Plan now for how to get to the facility for your delivery—save a little bit of money each week/each time you go to the market.
- When you are in labor, if you experience swollen feet (OTHER DANGER SIGNS), you must get to a clinic as soon as you possibly can.

After Delivery

- You still need care after the baby is born—it is still very important that you have your health care provider check you out within 6 hours, at 6 days and at 6 weeks after you have the baby.
- After you have the baby, it is also time to think about deciding on how you will ensure you will not have another baby until your body is ready. There are many safe options open to you—ask your health care provider for details.

Fathers-to-be

- Pregnancy is something that happens to a woman's body, but having a baby is happening to the family.
- A father's role is to help ensure the mother and the baby thrive:
    - Go with your wife/partner to at least 4 appointments before the baby is born
    - Save enough money (a little per week) to pay for transportation to get her to a health facility for delivery or in an emergency
    - Encourage your wife to return to the clinic for necessary checkups for her after she has the baby—within 6 hours, after 6 days and after 6 weeks.

- Your wife/partner's body needs time to rest between pregnancies to ensure that she stays healthy and delivers a big, strong baby.
- Planning your family means you are responsible. Talk to your partner about selecting a family planning method that is right for your family.

SMAGs

- SMAGs are critical in ensuring women heed the messages of safe motherhood; interacting with each mother on their own terms, validating their concerns and encouraging their excitement will allow you to develop a better relationship with the mother, ultimately resulting in her listening to your advice concerning her pregnancy and delivery

Traditional Leaders/Chiefs

- As the leader and opinion maker in the community, you/a chief can make a difference in life or death. Become a champion chief and encourage all pregnant women and their partners in your community to go for early and complete antenatal care and to deliver their babies in facilities.
- Mothers and babies do not only belong to that family, but to the community as a whole. It is our role to make sure they have the safest start to life and that those little babies have their mothers around to help them grow up.
- Traditional medicine is an important part of life, but not when it leads to death. Women do not need to die to become mothers of our children. As a chief, you have the power to make sure women and their families see that they can still respect their traditions AND have a modern, safe delivery.
- Safe motherhood means ensuring a woman goes for antenatal care at a clinic immediately when she finds out she is pregnant, completing at least 4 visits to antenatal care, delivering her baby in a health facility, and obtaining post-partum care at 6 hours, 6 days and 6 weeks after birth.

Health Workers

- Women deserve respect, a smile, no judgment and support in this amazing moment in their lives
- Health workers are the most important voice for a pregnant woman. Use this voice and utilize the new counseling checklist for ANC to wisely to counsel the mother to make the best choices possible for her.

General public

- Pregnancy is a time of joy but also of risk. We all must do our part to minimize the risks and celebrate the joy.
- Ensuring all women deliver in a facility is everyone's responsibility
- Possible roles include:
    - Help mothers save enough for transportation
    - Help take care of her other children when she goes to deliver or to the waiting home
    - Helping the mother out around her house/with chores like fetching water
    - Encouraging her to seek the necessary care

XI. Creative considerations

Tone:

This campaign will be built on the concept of togetherness, connecting to the collective spirit of Zambian communities and the concept that ensuring maternal health is ensuring the future. It is not an individual mother's responsibility alone to ensure her health and the well-being of her child, but rather also the responsibility of her family, her community and her nation.

Name:

To reflect the above overall tone of the campaign, possible campaign names include:

- Mama Wangu ("Our Mother")
- The Safest Mother
- My Mother
- Our Promise
- The Right Start
- No More
- Let's Live
- One Mother
- The heart of a mother

Options will be refined (and new possibilities generated) and will be pretested and finalized as part of the creative product development.

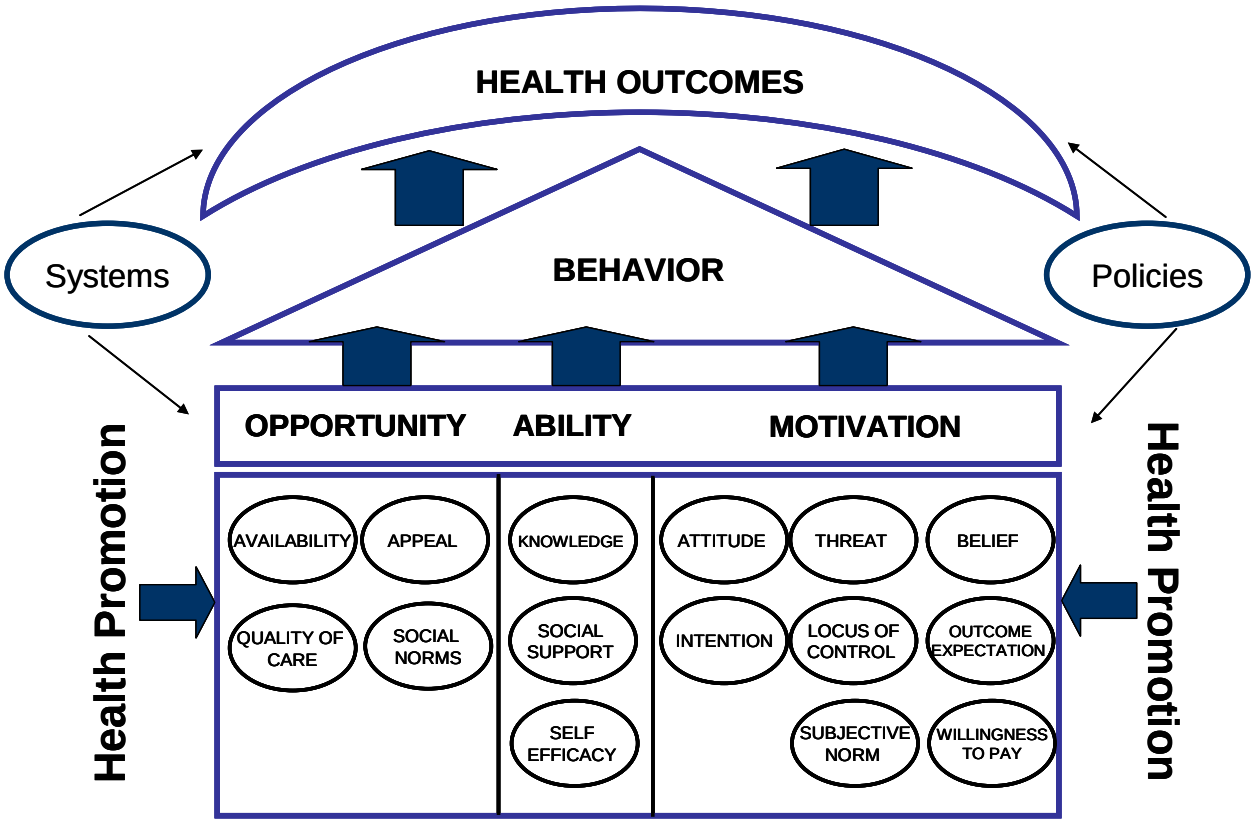
Look and Feel:

Communications products should be relatable to rural and urban mothers and their families. They should inspire pride and hope in the capacity of everyone to protect our mothers. Images should be bright and colorful, approachable and fun, rather than somber. The subject matter is serious, but the outcome is joy—a healthy mother and a healthy baby.

Local language:

All communications products should be as pictorially based as possible and any text will be translated into all appropriate local languages through a process of translation/back translation.

This model depicts the theory of behavior change upon which this campaign is predicated. It was originally developed by Population Services International, but has been adapted by the Manoff Group and CSH to better reflect the inputs of health promotion specifically.



Annex B: - Safe motherhood Implementation Plan

PRODUCT*	SPECIFICATION	# COPIES	COMPLETION DATE	PLAN FOR IMPLEMENTATION/USE
TV				
Change Champion/ Champion Chief documentary	20 minutes long, documentary-style film	1 master, 1000 copies	15 April, 2012	Media plan for documentary on ZNBC and MuviTV as well as a media tour to be submitted by agency 15th April. Premiere will be end of April/1 May and will be shown on repeat in coordination with media tour from May 2012 to May 2013. Will also be given to national and CSO partners to use in community mobilizing efforts starting May, 2012 (immediately after premiere)
Journey to Becoming a Parent documentary	4 parts, 15 minutes each part, documentary style, filmed on location	1 master, 1000 copies on DVD in English; 500 copies in each of local 7 languages	1 June, 2012	Media plan for documentary on ZNBC and MuviTV to be submitted by agency 15th June. Premiere will be middle of June and will be shown on repeat on the two channels from June 2012 to June 2013. Documentary will also be given to bus companies to include in their long-distance entertainment line-up starting in July 2012 (detailed plans for which including which routes and when the documentary will be shown will be negotiated with the bus operators once the product is ready) Will also be given to national and CSO partners to use in community mobilizing efforts starting June, 2012 (immediately after premiere)
RADIO				
Journey to Becoming a Parent documentary (same as TV, but for radio)	4 parts 15 minutes each part, documentary style, recorded on location	1 master, 5000 copies	1 June, 2012	Media plan for documentary on national and community radio stations to be submitted by agency 15th June. Premiere will be middle of June and will be shown on repeat on the two channels from June 2012 to June 2013. Will also be given to national and CSO partners to use in community mobilizing efforts starting June, 2012 (immediately after premiere)

PRODUCT*	SPECIFICATION	# COPIES	COMPLETION DATE	PLAN FOR IMPLEMENTATION/USE
Radio spots for women pre-pregnancy on family planning	30 second radio spot, 2 versions; English and 7 local languages	1 master in each language, 1000 copies in each language on CD.	15 April, 2012	Media plan for radio spots on national and community radio stations to be submitted by agency 15th May. Launch of these spots will be early June and will be shown on repeat on the two channels from May 2012 to May 2013. Will also be given to national and CSO partners to use in community mobilizing efforts starting June, 2012.
Radio spots for general public	30 second radio spots, 2 versions; English and 7 local languages		15 April, 2012 (English) 1 June, local languages copies	
Radio spots targeting men specifically	60 second radio spots, 2 versions; English and 7 local languages		15 April, 201 (English) 1 June, local languages copies 2	
District-specific radio spots	30 second radio spots recorded in 20 target districts in appropriate local language featuring local leaders promoting the messages	1 master with ALL recordings; 20 copies per district (400 total) of each recording.	15 April, 2012 for 5 selected districts; 15 May for 10 additional districts; 15 July 2012 for all complete (districts selected in conjunction with CSH and partners)	
PRINT				
Billboards	3 versions	20 copies	23 March, 2012	Media plan to be submitted by agency April 2012 and will be placed accordingly between April 2012 and April 2013
Print media advert	2 versions of full-page newspaper advertisements	1 master of each	23 March, 2012	
Change Champion program kits	Bag Folders Printed brochure on being a change champion (standard brochure size, full color 4 pages)	500 kits	15 April, 2012	Bag and program kits distributed via the House of Chiefs to all chiefs in Zambia May 2012 CSOs contracted by CSH also given materials (May 2012) to use materials directly to motivate chiefs to become a change champion

PRODUCT*	SPECIFICATION	# COPIES	COMPLETION DATE	PLAN FOR IMPLEMENTATION/USE
Fliers for men: two versions, one for fathers-to-be and one on men's role in family planning (detailed content provided by CSH)	Folded A4, full-color 4 pages (1 A4 page back and front, folded)	20,000 (10,000 each version)	23 March, 2012	All print materials will be delivered to CSH by agency on deliverable due date. We will disseminate 5% to Afya Mizuri, 30% to MOH to distribute directly to clinics, 15% to national partners not contracted and 50% to contracted CSOs to use them in various community activities. These activities should be underway by June 2012. We will collect detailed workplans including trainings and activities plans from the CSO partners once they are engaged (in April 2012).
Pictorial birth plans	• Tablet with tear-off pictorial birth plans (100 per tablet), non-laminated but cardstock, 2-color	10,000 (5000 were printed previously)	15 April, 2012	
Tool-kit/job aids for community volunteer	Includes: • Large-size freestanding A4size booklet with laminated pages, images on front and text on back; 15 pages • Tablet with "safe mother" certificates (cardstock) pre-printed, 100 certificates per tablet, 2-color	15000; local language translation need TBD (some of the 15,000 may be in other languages than English)	15 April, 2012 for whole toolkit;	
Brochure for general population (detailed content provided by CSH)	4 color, A4 size folded into three leaves, front and back with text and images	10,000	23 March, 2012	

PRODUCT*	SPECIFICATION	# COPIES	COMPLETION DATE	PLAN FOR IMPLEMENTATION/USE
Brochure for women pre-pregnancy on family planning (detailed content provided by CSH)	4 color, A4 size folded into three leaves, front and back with text and images	5,000	23 March, 2012	
Posters	5 versions A2 size	2000 copies of each version	23 March, 2012	
Counseling checklist (detailed content provided by CSH)	Laminated A4 size card, folded into three leaves to denote three trimesters of pregnancy	5000 copies	23 March, 2012	
Counseling tool for family planning (detailed content provided by CSH)	1 A4 size laminated card full color text front and back	5000 copies	23 March, 2012	
PROMOTIONAL ITEMS				
Chitenges	2M X 1M cloth printed with campaign name and logo and other safe motherhood messages	25,000	1 May, 2012	Will be distributed as promotional items as campaign rolls out s, mostly through contracted CSO partners
Banners	6M X3M; 3 versions	20 copies each version	23 March, 2012	Will be used as promo materials for launch/premiere events, media tours, etc…

Annex C: - Saving Mothers Giving Life M&E Framework

The SMGL program will be implemented over a period of five months in collaboration with other partners in Kalomo, Mansa, Lundazi and Nyimba.

Indicators	Disaggregation	Methodology/M&E Activities	Data Source	Frequency of Data Collection
Impact Level: Reduced maternal mortality rate/ratio				
Outcome Level				
Proportion of pregnant women who delivered in a health facility				
Proportion of women who have created a birth plan				
Proportion of women attending delivery accompanied by their male partner				
Proportion of women who seek all three post-partum check-ups				
Output level				
# of trained hospital staff in use of materials from SMGL	Disaggregated by: • Province • Sex of trainee	Training records review	Training participant lists	Once
# of SMAGs and/or community counselors trained in counseling on safe motherhood messages from SMGL	Disaggregated by: • Province • Sex of trainee	Training records review	Training participant lists	Once
# of patients treated and referred	Disaggregated by complication	Hospital/clinic records review	Hospital/clinic register	Monthly
Proportion of cases requiring blood transfusion that receive transfusion		Hospital/clinic records review	Hospital/clinic register	Monthly
# of Emoc cases referred and transported to other health centres	Disaggregated by complication	Hospital/clinic record review	Maternity register	
# of times "Journey to Becoming a Parent" TV and radio Documentary is aired per month	Disaggregated by: • Communication channel (TV and Radio)	Review of CSH activity completion reports and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
# of materials placed and/or mounted	Disaggregated by: Type of material	Review of CSH and CSO activity completion reports	CSH and CSO activity completion reports	Monthly

	(posters, flyers)			
# of times Change Champion/Champion Chief Documentary is aired per month	Disaggregated by: • Province	Review of CSH activity completion reports and monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
# of deliveries in a health facility attended by skilled health personnel?	Disaggregated by: Health facility	Hospital/clinic record reviews	Maternity register	Monthly
# of women who received a postpartum visit after giving birth	Disaggregated by • Health facility • Time of visit (6 hours, 6 days, 6 weeks)	Hospital/clinic record reviews	Postnatal registers	Monthly
Process Level Indicators				
Availability of health facilities with EmOC facilities	Disaggregated by: • Province • Health facility	Hospital/clinic inventory review	Facility inventory	Baseline/Endline
Availability of blood transfusion supplies	Disaggregated by: • Province • Health facility	Hospital/clinic record reviews	Maternity register	End term
Distribution of SMAG toolkit for mothers and mothers-to-be to Change Champions		Review of CSH activity completion reports and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Once
Creation of print materials for SMGL	Disaggregated by: • Type (posters, picture-based birth plan, counselling toolkits, flyers, brochures)	Review of CSH activity completion reports and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Once